

**Patriot Insurance Agency, Inc.**

DBA: Arizona Patriot Insurance Agency, Inc. in CA, NC, ND, NY

**P.O. Box 1298**

**Sonoita, AZ 85637-1298**

**Phone: 520 455-9252**

**Fax: 520 455-9358**

**Toll Free Number: 800 859-2724**

*Email: [wecare@patriot-insurance.com](mailto:wecare@patriot-insurance.com)*

*[www.patriot-insurance.com](http://www.patriot-insurance.com)*

## **DIRECTIONS FOR OBTAINING A QUOTATION**

Please find enclosed the application regarding Package Liability coverage to be completed. Please follow these easy steps to expedite your request for a quotation:

- Make sure that all questions are answered completely and as accurately as possible. Missing information will delay your quotation.
  - Make certain you sign the application. (Signing does NOT obligate you to purchase the coverage.)
- Brochure and/or Advertisements:
  - Yellow Pages, Newspapers, Church Bulletins, Brochures, TV/Radio
- A copy of the membership of an affiliation with a National Organization/Association.
- Should you have prior coverage, please provide three-year current loss runs (claims history report from carrier).
  - If no prior insurance, forward the Executive Director's resume.
- Sample contracts and/or hold harmless agreements used for contacted staff.
- Facility license (if required) for each location and/or operation.
- Photographs of each location.
- Financial Statement.
- Client Referral Guidelines.
- Personnel Procedures.
- If Hired and Non Owned is requested, provide.
  - Motor vehicle reports (MVRs).
  - Copies of personal auto policy declaration pages.

Should we be of further assistance, please contact our Underwriting Department at 800.859.2724. Thank you.

**Please forward all the above information to our agency via mail, fax or email.**

Thank you for allowing us to service your insurance needs and we look forward to working with you in the near future.

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**SOCIAL SERVICE INSURANCE  
PROGRAM APPLICATION**

**APPLICANT INFORMATION SECTION**

Organization's Legal Name:	
Name of Director/Contact:	
Mailing Address: <i>(Including City, State and Zip)</i>	
Physical Location Address: <i>(Including City, State and Zip)</i>	
Telephone Number:	
Fax Number:	
Email Address:	
Web Page Address:	
Federal Identification Number:	

**WARRANTY**

Please understand that your answers and responses throughout this application serves as a warranty. Your completed application will become part of the wording and conditions of your organization's policy. Therefore, any misrepresentation or omissions made on this application may void any or all coverage benefits under these policies. Your signature below acknowledges that you understand this warranty and certifies your responses to be true and correct. Revocable Proxy. The undersigned hereby appoints Roberta Renzi and Erika Hill of the Board of Directors of The International Association of Community Service Organizations (the "Association"), and each of them, as proxy, with full power of substitution, to cast all votes that the undersigned Member is entitled to cast at any meeting of the Association and to act with respect to all votes that the undersigned would be entitled to cast until the earlier of the time that this proxy is revoked or three years from the date that this instrument is executed and delivered to the Association.

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Name *(printed)* \_\_\_\_\_ Title: \_\_\_\_\_

**LOSS EXPERIENCE SECTION**

Over the last four years have any claims, incidents or lawsuits been brought against your organization or affiliated organization? YES\*  NO

*\*If yes, please attach detailed claim information with the date of loss or occurrence, the status, the amount reserved or paid and a description of the claim or allegation.*

# SOCIAL SERVICE INSURANCE PROGRAM APPLICATION

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## DESCRIPTIONS OF OPERATIONS SECTION

Please describe your organization's operation, purpose, and daily functions.  
(Please use a separate sheet of paper if more space is required.)

1. Are you affiliated with a National Organization/Association? If yes, please indicate \_\_\_\_\_
2. Do you have a maternity home or operate an overnight facility?    YES     NO   
Do you provide 24 hour residential care?    YES     NO   
Do you provide childcare services?    YES     NO   
Do you provide a sheltered workshop?    YES     NO   
Do you operate a camp?    YES     NO   
a. \*\* If yes, Are you licensed by the state(s) in which you operate?    YES     NO   
    (Please attach copy of license and latest inspection.)  
b. Is it renewed:     Annually     Semi-Annually     Other: \_\_\_\_\_
3. Are you a multi-location organization?    YES\*     NO   
    *\*If Yes, please attach (on a separate sheet of paper) a schedule which will contain the following information for each location: (1) the physical location address, (2) the hours of operation per week including weekends, if applicable (3) a description of the services provided to your clients.*
4. Average number of hours per week the main location is open: \_\_\_\_\_
5. Average number of Employees: \_\_\_\_\_      Average number of Volunteers: \_\_\_\_\_
6. Are you organized as a 501(c)(3) nonprofit organization?    YES     NO
7. **Effective Date Organization Began Service:** \_\_\_\_\_
8. **Date of Incorporation of your Organization:** \_\_\_\_\_
9. **Number of years under current management?** \_\_\_\_\_

10. Has any insurance ever been denied, cancelled or non-renewed?    YES     NO

If yes, please explain: \_\_\_\_\_

11. Name of present insurance carrier for General Liability and Professional Liability:

\_\_\_\_\_

**Expiration Date:** \_\_\_\_\_

**Premium:** \_\_\_\_\_

# SOCIAL SERVICE INSURANCE PROGRAM APPLICATION

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## PROFESSIONAL LIABILITY SECTION

1. Is there an established training and continuing education program provided for all counselors? YES  NO
- A. If Yes, are the harsh techniques of employing the pressures of guilt or mental anguish rejected as an appropriate counseling procedure? YES  NO
- B. If yes, attach explanation of training program.
- C. Are clients referred to specialists when appropriate? Yes  No
2. Are files maintained to protect confidentiality of clients? YES  NO
3. How often does the Director/Administrator conduct a performance review with the individual counselors? \_\_\_\_\_  
Is this review done in writing? YES  NO
4. Do you refer your clients to any third parties? YES  NO
- If Yes, please list: \_\_\_\_\_
- If Yes, do you have a Hold Harmless Agreement signed by your client? YES  NO
5. Do you provide rape, sex abuse, suicide, spouse abuse, substance abuse, or other extensive social service counseling?  
YES\*\*  NO
- \*\*If so, this Insurance Program **does not** cover the exposures associated with operating these extensive social service operations as described above. We have a separate program available to cover these exposures. (Please call for information.)*
6. Please provide the annual number of client contacts (visits, call-in etc.) for the following services:
- |   | <u># of Visits</u> |
|---|--------------------|
| Individual counseling                               | _____              |
| Group counseling                                    | _____              |
| Mentoring   | _____              |
| Family/Independent Living Skills Training           | _____              |
| Other types of counseling ( <i>describe below</i> ) | _____              |
7. Is the staff required to report to the administrator all incidences that may result in a claim? YES  NO
8. Are written records of all incidences kept by the administrator? YES  NO
- Are all incidences reviewed? YES  NO
9. Do you have a formal written safety program in place? YES  NO
10. Is the staff required to report to the administrator all incidences that may result in a claim? YES  NO
11. Is a complete criminal background check required for all staff members YES  NO
- County criminal record search  State criminal record search  National criminal index search  
 State prison search  Federal prison search  Sex offender search  criminal index search  
 Teacher license  Education verification
12. Is a complete background check required for all volunteers the same as for employees? YES  NO
13. Explain what background checks are done & if so, what method is used?
14. Average number of volunteers daily: \_\_\_\_\_
15. Describe the volunteers' duties: \_\_\_\_\_

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## GENERAL LIABILITY SECTION

1. Does your location maintain dry floors, unobstructed walkways and halls during operating hours in order to reduce the exposure to accidental slip and fall claims?  
YES  NO

2. Many landlords require General Liability limits of \$1,000,000 per location. Does this amount adequately meet the requirements of your lease?  
YES  NO\*  \*If not, what Liability Limit is required? \_\_\_\_\_

3. Do you have a formal written safety program in place? YES  NO

4. Does the facility have a written emergency evacuation plan? YES  NO

*\*\*Program automatically includes \$1,000,000 General Liability Limit. Additional excess Umbrella limits may be purchased. Please call for an application.*

5. **YOUR ADDITIONAL INSURED:** Insurable Interest – check the box that applies:

Name: \_\_\_\_\_  Funding/Placement  Landlord  
 Contract/Service  
Address: \_\_\_\_\_  Other: Please Describe: \_\_\_\_\_  
\_\_\_\_\_

6. Do you lease or sub-lease to others any portion of the locations scheduled on the application? YES  NO   
a. If yes, do you require that your tenant carry liability insurance for the Occupancy? YES  NO   
b. If yes, how do you make sure the coverage is maintained? \_\_\_\_\_

7. Please describe your fundraising activities including special events. Please list the types of activities, number of participants, what items are sold, etc.  
\_\_\_\_\_

8. Is care taken in planning and coordinating your fund raising activities? Specifically, do you require all vendors or equipment suppliers to provide a Certificate (proof) of Insurance, prior to remitting payment for their services? YES  NO

9. In the past have you safely planned and managed crowd control, movement, and overflow parking during your events?  
YES  NO

10. When you hold a meeting or event is care taken when using property of a Third Party (such as: church, school, etc?)  
Yes  No

11. Are volunteers, employees, or those working at your center covered by Workers Compensation Insurance or Personal Health Insurance or Group Medical Insurance?  
YES  NO

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## PERSONNEL SECTION

Positions	No. of Employees	No. of Volunteers	No. Contracted	Number Licensed
Administrators				
Counselors				
Psychologists				
Nurses, RN/LPN				
Social Workers				
Clerical				
Physicians				
Others:				
Others:				

## ADVERTISING LIABILITY SECTION

1. Please indicate if you advertise in the?  
 Newspapers  Yellow pages  Bulletins  or other print media ?  
 YES\*  NO   
 If Yes, what Headings are used: \_\_\_\_\_
2. Do you advertise on the radio  or television  ? \*\* YES  NO
- If either media is utilized, does the script include any ambiguous terminology while describing exactly what services you provide? YES  NO
- \*\*PLEASE INCLUDE A COPY OR SCRIPT OF YOUR RADIO OR TELEVISION ADVERTISEMENT.**

## HIRED AND NON-OWNED AUTO LIABILITY SECTION

*(Subject to Underwriting Approval)*

1. Do you provide transportation for your clients? YES  NO
2. Do employees, workers, or volunteers use their vehicles on behalf of the organization? YES  NO   
**It is management's responsibility to establish and enforce drive selection criteria**
3. Do you order Motor Vehicle Reports (MVR) annually for all employees and volunteers driving their vehicles on your behalf?  
 YES  NO
4. Do you have a procedure for evaluating MVR's to identify unacceptable/marginal drivers? YES  NO
5. Does the Organization verify that the employees or volunteers have their own vehicles properly insured? YES  NO   
**PLEASE NOTE: Evidence of adequate insurance must be updated annually.**

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## OPTIONAL: PHYSICAL & SEXUAL ABUSE SECTION (Subject to Underwriting Approval & Additional Premium)

1. Does your state permit you to do criminal background investigations on prospective employees/volunteers?  
YES  NO 
  - a. If yes, do you routinely request and receive such background investigations? YES  NO
  - b. If yes, how often? \_\_\_\_\_
2. Do you verify employment related references? YES  NO
3. Do you verify educational requirements? YES  NO
4. Do you conduct a personal interview? YES  NO
5. Are professional licenses checked for employees/volunteers? YES  NO
6. Do you provide new employee orientation? YES  NO
7. Do you discuss at staff orientations, physical and sexual abuse issues, how to recognize the signs and what to do if a client reports someone molested him/her? YES  NO
8. Do you have a plan of supervision that monitors staff in day-to-day relationships with clients? YES  NO
9. Do you have a crisis management plan for dealing with staff, victim, parents, authorities and media if you have an incident of abuse? YES \*\* NO 
  - a. If Yes, please attach a copy.
10. Have you ever had an incident which resulted in an allegation of sexual abuse? YES  NO
11. Was a claim ever made against you? YES  NO